

## MINUTES

### *eHealth Care Quality and Patient Safety Board Patient Care Workgroup September 7, 2006*

Attending: Ed Barthell, Kathleen Blair, Lowell Keppel, Denise Webb, Kathy Steele, Arthur Wendel, Herb Thompson, Murray Katcher, Stacia Jankowski, Seth Foldy

Guest (and new Resource): Jesi Wang

Unable to attend: Jon Temppte, Frederic Wesbrook, Dana Richardson, Sandy Bissen

#### **Agenda Item**

##### **1. Approval of minutes**

Minutes of August 10 and August 24 approved without change.

##### **2. HIT Adoption and Implementation: Issues and Recommendations**

###### **a. Lessons Learned from DOQ-IT: JESI WANG (METASTAR, INC.)**

Currently working with 50 primary care practice sites on EMR and quality system implementation. (Geographic sites, not necessarily 50 practices.) Only 25% of practices making a commitment implement in 2 years; those with a contract to buy have much higher rate. Lessons learned:

- Practices must ID benefits up-front to overcome cost-aversion.
- Selection: Goal-setting must be performed to match with proper product.
- Time: Champions and project managers often underestimate time commitment- as much as 50% of their time for parts of implementation process.
- Structure: Often no experience with setting up interdisciplinary team to get appropriate input into workflow design.
- No adoption plan yields poor adoption by practice staff- some practices have little point-of-care use 3-4 years after implementation.
- ASP (Internet-served) models are becoming more popular with smaller practices.
- Smaller practices implement and adopt faster once decision and funding settled.
- Decisions about EMR unlike most other practice decisions--they have no model to work from.
- Analyzing workflow and improving workflow too rarely done.
- Most practices state they are adopting because is inevitable.
- Major concerns include: fear worse communication with pt. with computer in room; fear decline in pt. satisfaction; poor typing skills/keyboard phobia.
- Physician champions may not know what is expected of them. They may not be respected by others, which is important.
- New CCHIT certification appears to improve confidence in buying.
- Consider 2-3 years for full implementation/adoption process. May add as much as 1 year after "go" decision to secure funding, select vender, negotiate

contract.

Workgroup members asked about tools used: over 25 recorded webcasts on critical parts of process, many decision tools, face-to-face consults and regular teleconferences. See <http://www.metastar.com/web/Default.aspx?tabid=218> . About 875 primary care sites invited, 150 stepped forward, 50 able to be selected. Demand exceeded supply by 3:1 in early stages.

**b. Comments from WHA Medical and Professional Affairs: Dana Richardson**

Dr. Foldy summarized her written report (sent with minutes).

**c. Group discussion and recommendations. Recommendation draft language**

- DOQ-IT effort should be supported and expanded: retain, maintain and expand the experience base available for EMR adoption and implementation and expand it to specialty.
- Wisconsin should ultimately subsidize only HIT which is CCHIT certified and adhere to AHIC (and possibly narrower Wisconsin?) standards.
- [Could rank HIT vendors for their degree of compatibility with Wisconsin exchange interoperability standards. For example, HealthBridge (Cincinnati) gives Platinum rank to EMRs which are interfaced to incorporate HB-delivered results, utilize HB-electronic ambulatory ordering and contribute to HB-clinical repositories. Fewer functions, cheaper metals (gold, silver, etc.).]
- Economic incentives or consequences from Wisconsin government payers (e.g., Medicaid, Employee Trust Fund) could foster greater HIT adoption. Most effective if consistent expectations from both public and private plans. Pay-for-performance incentives can, if appropriately implemented, accelerate HIT adoption. [See "eHealth Initiative Foundation. "Parallel Pathways for Quality Healthcare: A Framework for Aligning Incentives with Quality and Health Information Technology."

[http://toolkit.ehealthinitiative.org/value\\_creation\\_and\\_financing/resources.msp?Section=384&Category=402&Document=788](http://toolkit.ehealthinitiative.org/value_creation_and_financing/resources.msp?Section=384&Category=402&Document=788) ]

**3. Revised use case document: Does this reflect what we want to achieve?**

See Ed's redraft and diagram and Seth's diagram.

- Suggestion adopted to add an "Actor" bubble to the use case actor diagram for "Payers (disease management and care coordination)."
- Add bubble for Immunization Registries to "systems."
- Transmission of a registration message in 1A constitutes documentation of the "treating clinician" status of the health exchange user and thus authorizes the HIE to share information with that treating clinician.
- Consistent with the preceding point: Requirements for patient consent for sharing electronic information between *treating professionals* should mirror current Federal HIPAA language. Thus requirements for explicit patient consent (whether opt-in or opt-out) to share specific subcategories of information (e.g., mental health or HIV results) with *treating* clinicians should be eliminated or minimized in state and Federal laws. There is stipulation of excellent HIE confidentiality and security, including consequences for breach of confidentiality or security.

#### **4. Vetting eHealth Board conclusions with clinical stakeholders: Plan for Listening**

**Session** - All members to send suggested additions to listening session invitees directly to Stacia or to Seth. Others who should be invited include: Wisconsin chapters of American Academy of Pediatrics, Am. College of Physicians, Am. College of Emergency Physicians, academic partners like the Center for Urban Population Health (UW/UWM/Aurora), UW Population Health Institute, UWM Center for Urban Initiatives and Research, MCW dean for community health.

- Agreed to reserve Sept 21 meeting for joint session with Information Exchange Workgroup to develop common recommendations.
- Stacia is soliciting availability for week of October 9 for the listening session. Mid-location like Oconomowoc approved for listening session.

#### **5. Review materials from other workgroups:**

##### **a. Architecture Principles: IE workgroup**

- Concerned about absolute endorsement of "thin" and "decentralized" network. Enable HIEs to use repositories when required.
- Health Information Exchanges supported by Wisconsin should be "agnostic" to vendor: so long as standards are met any vendor's systems or products should be able to participate in exchange.
- Health Information Exchanges supported by Wisconsin should be open to all patients, from all payers and health plans, and all providers, who are willing to adhere to the conditions of membership. An exchange established exclusive to or inside a particular payer, plan or provider organization does not meet the definition of Health Information Exchange under this recommendation.
- The group was unclear how Phase 1 of the HIMSS-EHR Vendors Association related to our early use cases. Exchange of structured summaries might come later. The use of the term Access Control in Phase 3 was also unclear to the group.

##### **b. Draft Financial Principles from CI workgroup**

- Under (3): "Access should be available in a manner that does not disadvantage those without ready access to the Internet" - the group felt this might be unrealistic. "Universal ready Internet access" should instead be part of the goal for the eHealth Action Plan. Creating non-Internet access to HIE for patients might be technically unfeasible and also sets up new silos for health information separate from other types of information. (One practical non-Internet access point that can be preserved is receiving information summaries from the patient's health care provider as already stipulated in HIPAA.)
- Under both (3) and (4) addition of "consistent with HIPAA requirements" is suggested to avoid over-generalizing the types of information, and types of information access, which consumers should expect from HI Exchanges.

**6. Next Meeting:** Thursday, September 21, TIME AND LOCATION MAY CHANGE GIVEN JOINT MEETING WITH IE WG.